To expedite processing, please send the following information with prescription.

- ☐ Referral Form
- ☐ Demographic Sheet
- ☐ Most Recent Clinical Notes
- ☐ List of Tried and Failed Meds (Including other Biologics)
- ☐ Prescription Insurance Card (Front & Back)

Bio-Coordinator or Primary Point of Contact at Clinic:

Name: ______________________________

Email: ______________________________

Direct Phone Line: ______________________________

Cell (optional, but preferred): ______________________________

Genefic Specialty Pharmacy
2577 Mall Road, Suite B
Florence, AL, 35630

Phone: (833) 928-7660
Fax: (833) 928-7661
Website: GeneficRx.com

Faxed prescriptions will only be accepted from a prescriber. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Genefic Specialty Pharmacy.

Dermatology Injectable Enrollment Form A - H

Prescriber:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Phone:	Fax:
Contact:	

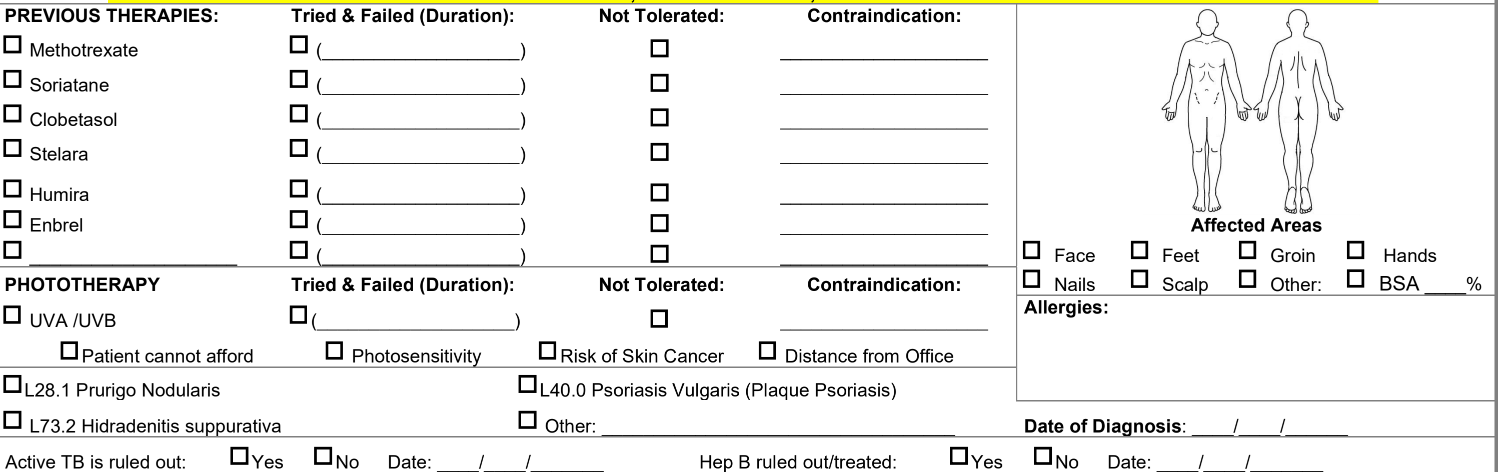
PATIENT INFORMATION

Name:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: ____/____/________	SS#: ____-____-________
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	☐ English ☐ Spanish ☐ Other: ________	Wt.: ________ Ht.: ________

PRESCRIPTION

Has the patient received a loading dose/starter kit? ☐**Yes Start Date:** ____/____/______ ☐**No** | **SHIP TO:** ☐**Patient's Home** ☐**Doctor's Office** ☐**Other:**____________

Drug		Directions & Quantity	Refills
Cimzia®	☐ Pre-filled Syringe ☐ Vials	☐ Inject 400 mg SQ every other week (Quantity: 4)	
Cosentyx®	☐ Sensoready Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 150 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 5) ☐ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Quantity: 1) ☐ **INITIAL:** Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 10) ☐ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Quantity: 2)	
Dupixent®	☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 600 mg SQ (two 300 mg injections) at week 0 (Quantity: 2) ☐ **MAINTENANCE:** Inject 300 mg SQ every **other** week starting at day 15 (Quantity: 2)	
Enbrel®	☐ SureClick® Pen ☐ Mini® with AutoTouch® ☐ Pre-filled Syringe	☐ **INITIAL**: Inject 50 mg SQ twice weekly (72-96 hours apart) for 3 months (Quantity: 8 with 2 refills) ☐ **MAINTENANCE**: Inject 50 mg SQ weekly (Quantity: 4)	
Humira® ***Citrate Free***	☐ Psoriasis Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 80 mg SQ on day 1, 40 mg on day 8, then 40 mg every **other** week (Quantity: QS 28 days) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2)	
	☐ HS Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 160 mg SQ on day 1, then 80 mg SQ on day 15 (Quantity: QS 28 days) ☐ **MAINTENANCE:** Inject 80 mg SQ every **other** week starting on day 29 (Quantity: 2) ***PEN ONLY*** ☐ **MAINTENANCE:** Inject 40 mg SQ every week starting on day 29 (Quantity: 4)	



MEDICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY*****

PREVIOUS THERAPIES:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ Methotrexate	☐ (____________)	☐	____________
☐ Soriatane	☐ (____________)	☐	____________
☐ Clobetasol	☐ (____________)	☐	____________
☐ Stelara	☐ (____________)	☐	____________
☐ Humira	☐ (____________)	☐	____________
☐ Enbrel	☐ (____________)	☐	____________
☐ ____________	☐ (____________)	☐	____________
PHOTOTHERAPY	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ UVA /UVB	☐ (____________)	☐	____________

☐ Patient cannot afford ☐ Photosensitivity ☐ Risk of Skin Cancer ☐ Distance from Office

Affected Areas

☐ Face ☐ Feet ☐ Groin ☐ Hands
☐ Nails ☐ Scalp ☐ Other: ☐ BSA ____%

Allergies:

☐ L28.1 Prurigo Nodularis ☐ L40.0 Psoriasis Vulgaris (Plaque Psoriasis)

☐ L73.2 Hidradenitis suppurativa ☐ Other: ________________________ **Date of Diagnosis**: ____/____/______

Active TB is ruled out: ☐Yes ☐No Date: ____/____/______ Hep B ruled out/treated: ☐Yes ☐No Date: ____/____/______

Additional Clinical Information:

American Academy of Dermatology Consensus Statement on Psoriasis Therapies

☐ Psoriasis is covering greater than 10% of body surface area ☐ Psoriasis is on palms, soles, head and neck, or genitalia ☐ Psoriasis occurs in conjunction with pain, swelling, or stiffness in joints
☐ Psoriasis patient needs more aggressive therapy due to impact on ability to perform daily activities, employment or interpersonal relationships

INJECTION TRAINING

☐ Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ Genefic to coordinate injection training

PRESCRIBER SIGNATURE

To Prescriber: By signing this form and utilizing our services, you are also authorizing Genefic Specialty Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescriber: **Date**: ____/____/________

CONFIDENTIALITY NOTICE

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.